SAVE PRINT CLEAR

AUDIT REFERRAL FORM

Claims administrator / Company name	Injured worker name
Address	Claim number
City, state, ZIP	Date of injury
Date or period of violations	Employer

SPECIFIC DETAILS OF COMPLAINT

List the nature of the complaint, being as specific as possible. For example, late payments of temporary or permanent disability (the number of late payments, if known), failure to pay temporary or permanent disability, vocational rehabilitation maintenance allowance, or 10% self-imposed penalties for late payments (indicate the periods not paid, if known), failure to provide vocational rehabilitation services when indicated, failure to pay or object to medical treatment or medical-legal bills, failure to investigate a claim, unsupported denial of liability for a claim, et al. Please attach copies of supporting documentation, if available.

Complainant (name & title) _____ Date _____

Address, city, state, ZIP _____